

**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

**In the Matter of the Statement of)
Issues Against:)**

Kaying Xiong)

Case No. 800-2015-015789

Respondent)
_____)

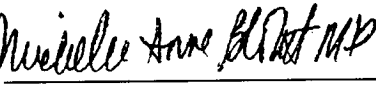
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 6, 2017.

IT IS SO ORDERED December 8, 2016.

MEDICAL BOARD OF CALIFORNIA

By: 
**Michelle Anne Bholat, M.D., Chair
Panel B**

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Statement of Issues
Against:

KAYING XIONG, M.D.,

Applicant.

Case No. 800-2015-015789

OAH No. 2016020961

PROPOSED DECISION

This matter was heard before Administrative Law Judge Jill Schlichtmann, State of California, Office of Administrative Hearings on August 3 and September 9, 2016, in Oakland, California.

Deputy Attorney General Greg W. Chambers represented complainant Kimberly Kirchmeyer, the Executive Director of the Medical Board of California.

Respondent Kaying Xiong, M.D., was present and represented by Justin D. Hein, Attorney at Law, Simas & Associates.

The record was left open for receipt of closing briefs. The briefs were timely received and marked for identification.

The matter was submitted for decision on October 14, 2016.

FACTUAL FINDINGS

Introduction

1. Kimberly Kirchmeyer (complainant) is the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs. She brought the statement of issues solely in her official capacity.

2. On December 9, 2014, the Board received an application for a Physician's and Surgeon's Certificate from Kaying Xiong, M.D. (respondent). Respondent indicated on her

application that she had received partial or no credit for a post graduate training program, had been placed on probation with limitations or special requirements, and had resigned from the program.

3. The Board denied the application on July 15, 2015. Respondent timely appealed and this hearing followed.

Respondent's Background

4. Respondent immigrated to this country with her parents from Laos as a young child. She and her parents are refugees of the war in Southeast Asia from the minority Hmong population. They settled in the Fresno, which has a Hmong population of approximately 25,000 individuals.

5. Respondent graduated from California State University, Fresno, in 1996 with a Bachelor of Arts degree in chemistry. She was on the Dean's List in 1994 and 1995.

6. Respondent received a single subject teaching credential in science and chemistry in 1996. From 1996 to 2005, and 2006 to 2007, respondent worked as a science teacher at Roosevelt High School in Fresno, California. Respondent's credential was reissued in 2016, and she has recently been working as a substitute teacher for the Fresno Unified School District.

7. Respondent graduated from the University of Wisconsin School of Medicine & Public Health in 2012. Respondent earned her degree in five years instead of four years for the following reasons: respondent failed USMLE Step 1 on the first attempt and had to postpone her third year clinical rotations for a few months to prepare for reexamination. After passing the examination, she resumed clinical rotations; however, they were further postponed after respondent's father and father-in-law passed away a few months apart. Additionally, toward the middle of her rotations, respondent was diagnosed with cervical cancer and underwent treatment, delaying her rotations.

Respondent's Residency at Banner Good Samaritan Medical Center

8. Respondent was matched with the Banner Good Samaritan Medical Center internal medicine residency program in Phoenix, Arizona. She began her first year, referred to as PGY1 (Post Graduate Year 1) or internship, on June 23, 2012.

9. In July 2012, Drs. Bergin, Boone and Novoa-Takara met with respondent regarding concerns observed during her first month of her internship. Dr. Novoa-Takara planned to follow up with coaching respondent. In August 2012, Sandra Till, M.D., met with respondent to give her feedback on her presentation. The presentation was disorganized and difficult to follow. Dr. Till provided respondent with an organizational strategy.

10. In August 2012, the Internal Medicine Clinical Competency Committee (CCC), a subcommittee of the Resident Advisory Committee (RAC), documented concerns about respondent's performance expressed during her neurology rotation. The CCC assigned her to work with Dr. Novoa-Takara's team in September 2012.

11. In September 2012, Lori Porter, M.D., expressed concerns with respondent's interpretation of lab data, and found that respondent still required a lot of guidance in selecting appropriate diagnostic tests. She complemented respondent for working very hard, taking recommendations seriously, becoming more independent and better at organizing patient information. Dr. Porter met with respondent and explicitly reported her concerns with respondent's deficiencies.

12. On October 25, 2012, the CCC issued respondent a letter of concern due to deficiencies in patient care, medical knowledge, interpersonal and communications skills, and practice-based learning and improvement. The CCC documented that in the first month of inpatient wards, respondent had difficulty presenting a concise history and physical, and developing a problem list and differential.

With coaching, by the end of her second month of wards, respondent continued to have problems with her differentials and overall medical knowledge. To facilitate more rapid improvement, respondent's schedule was modified to allow her to be an additional intern for two-week stretches on two different teams. Respondent was removed from night float and weekend coverage to allow her to focus on reading about her patients. Specific tasks were outlined to enable her to meet expected outcomes.

13. In November 2012, the CCC determined that it would move respondent to the VA as an extra intern; respondent agreed to the plan.

14. In January 2013, the CCC reported that respondent's intraining examination score was in the seventh percentile. The CCC noted that respondent was a hard worker and had shown some improvement, but there was a concern that her improvement might be insufficient to progress. Respondent's ability to identify a patient's central problem, and her ability to work unsupervised on Veterans Administration Hospital (VA) night float the following month, were discussed.

15. On January 29, 2013, Christina Bergin, M.D., discussed her concerns with respondent. One concern involved respondent's need to leave for an appointment without sufficient advance notice. The second issue involved respondent's delay in completing medical record documentation.

16. On February 4, 2013, the CCC notified respondent of continuing concerns and informed her that she may not progress on time to the supervisory role of a PGY2. Respondent was not up-to-date with her required MKSAP¹ modules despite medical

¹ MKSAP stands for Medical Knowledge Self-Assessment Program.

knowledge being a concern. Respondent was directed to: 1) work on her medical knowledge; 2) continue to work on efficiency, developing concise case presentations; and, 3) work with supervising residents and attendings at the beginning of each rotation to confirm her understanding of their expectations and to develop specific mutual learning goals. The CCC was concerned about respondent's scores on the intraining examination and her evaluations. The CCC advised respondent that it would be following her progress with the acquisition of general medical knowledge. Respondent was directed to develop a study plan with her advisor, Dr. NovoaTakara.

17. On February 15, 2013, Dr. NovoaTakara advised Cheryl O'Malley, M.D., the Program Director, that respondent had told Dr. NovoaTakara that she only studies from review books and by answering questions. Respondent stated that she never really read her textbooks. Respondent felt overwhelmed by reading MKSAP, which Dr. NovoaTakara considered just the beginning. Dr. NovoaTakara concluded that because respondent did not have a foundation in medical knowledge, MKSAP would be new rather than a review. Dr. NovoaTakara was working on a study plan with respondent.

18. In March 2013, due to performance concerns, as well as respondent's request for additional remediation activities, respondent was removed from her scheduled rotations as a VA night float doctor. She attended a one-month course in Chicago on didactic/study skills called the "Pass Program." The Pass Program helps residents who are struggling with learning and studying for board examinations. Respondent initiated and paid for the program.

19. In April 2013, an essential plan for improvement was to be created by Ruth Franks Snedecor, M.D. Due to continued concerns about her performance on the VA rotations, respondent was taken off of her VA duties and required to complete a remediation rotation at a simulation center. The concerns about her performance were discussed with respondent in detail.

20. On June 5, 2013, respondent attended a patient simulation at the Banner Good Samaritan Medical Center simulation center. The scenarios were videotaped and available for respondent to review. The scenario involved a patient with a migraine. Respondent missed most of the red flag questions and had no idea how to treat the patient. Dr. Snedecor expressed significant concerns about respondent's performance on the patient simulations. Respondent had difficulty determining the appropriate treatment plans, was unable to order appropriate evaluation studies, and struggled to initiate correct antibiotic choices for common inpatient infections, identify the central problem and convey the appropriate evaluation and treatment of a patient. These concerns were conveyed to respondent.

21. On the late afternoon of June 5, 2013, respondent met with Jayne Peterson, M.D., Chair of the CCC, who expressed concerns about respondent's progress.

22. Respondent attended a second patient simulation on June 6, 2013. The patient had pneumonia. Respondent was unable to determine a differential as to what type of

pneumonia and what medication to give. She failed to ask the appropriate history questions or express concern for the patient.

23. Respondent also attended clinic on June 6, 2013. She was observed with a patient with chest pain and diabetes. Respondent failed to ask pertinent questions to substantiate her differential. She was unable to apply her medical knowledge to a patient to obtain an accurate history. Her inability to know how to treat a patient resulted from a lack of communication.

24. On June 10, 2013, the CCC met to discuss respondent's performance. In addition to the result of the patient simulations and ongoing issues in clinic, there were concerns regarding respondent's memory and her inability to remember information a few minutes after hearing it. It was noted that she needed to write everything down. The CCC questioned whether her memory loss resulted from her past medical issues, including treatment for breast cancer. The CCC concluded that respondent would remain on intern status from July to September 2013, with specific monitoring of performance and coaching on improvement of differential and treatment and obtaining an accurate patient history.

25. On June 28, 2013, Drs. Peterson and O'Malley issued a letter of concern to respondent. The letter indicated that respondent had not completed the requirements of the internship despite three months of remediation. The CCC had allowed respondent three additional months to work as an intern. The RAC advised respondent that while her contract stated that she was a PGY-2, her level of responsibility would remain at the PGY-1 level.

26. In July 2013, respondent worked with Laura Durling, M.D. Dr. Durling reported that respondent needed to improve her knowledge base and ability to devise a treatment plan for her patients. However, she felt that respondent had improved over the month and was open to feedback.

27. Respondent also worked with Brenda Shinar, M.D., during the month of July 2013. Dr. Shinar reported that respondent was unable to function as an intern. Respondent was unable to remember information discussed or read previously. She was unable to ask the appropriate questions of a patient to confirm her differential, and her notes were inaccurate.

28. In August 2013, during an ambulatory rotation, respondent's schedule was modified to lower her patient volume. Dr. Peterson supervised respondent's work during the month of August. She found respondent needed improvement in many areas. Respondent struggled to gather information in a timely manner. She had trouble getting to the specific clinical problem. She was unable to formulate an effective plan and management strategy for patient care, and was inconsistent in her ability to select appropriate diagnostic tests. Respondent was unable to consistently pull information together into a concise case presentation. Dr. Peterson met with respondent to discuss her poor performance that month.

29. The CCC met on August 12, 2013, to discuss respondent's progress. Dr. Peterson was concerned about respondent's memory; respondent acknowledged her memory

issues, but had not pursued the issue with a physician. The committee felt that respondent lacked insight and was not showing improvement. The CCC recommended referring the matter to the RAC for disciplinary action.

30. On August 16, 2013, Lise Harper, M.D., who had worked with respondent in August 2013, wrote to Dr. O'Malley stating:

[Respondent] did not know the therapeutic dosing for lovenox² despite having put a pt on it for treatment of an acute [deep vein thrombosis]. She also did not take the time to look it up knowing that we were going to change the dose based on pt's significant weight loss.

* * *

Notes were often inaccurate and without prioritization of acute issues.

* * *

Overall, she did not seem interested in trying to solve problems/look things up/figure out how to best manage a patient, but rather just waited to be told what to do by her senior.

* * *

I did not trust her to be able to recognize [critical] issues with the patients or relay important information to consultants. I had significantly greater confidence in her co-intern with 12 months less experience.

31. On August 29, 2013, the CCC issued a letter of concern to respondent. Despite being evaluated based upon 12 months of residency, she had completed 15 months yet, her performance remained deficient. The letter detailed the required milestones and critical feedback she had received during July and August 2013. The CCC noted that attending physicians perceived that respondent was unaware of her deficiencies and she was not demonstrating initiative in finding out information or initiating improvement. Drs. Snedecor, Peterson, Bergin and Shinar expressed detailed concerns about respondent's performance. The deficiencies were identified so that respondent could develop a plan to help demonstrate to the RAC that she was achieving the required skills. Respondent was notified that the RAC would be meeting to discuss disciplinary action.

² Lovenox is an anticoagulant used to treat deep vein thrombosis.

32. Respondent worked with Adebisi Alli, M.D., during September 2013. Dr. Alli reported that respondent worked hard, and showed compassion toward patients and a desire to improve. Respondent gave a great presentation on congenital angioedema. Dr. Alli recommended that respondent continue to improve her understanding of the concept of sick patients as they discussed throughout the month, but felt she showed improvement and if she mastered the concept and worked hard, she would become a strong resident.

Respondent also worked with Emily Mallin, M.D., in September 2013. Dr. Mallin reported that respondent's physical examination skills were lacking and that she had missed a loud murmur and lung findings on two separate patients. She was also struggling with basic medical knowledge. However, Dr. Mallin noted that respondent's case presentations improved over time, and overall her skills improved over time.

33. On September 16, 2013, the CCC met to discuss respondent's progress. There were continued concerns about respondent's poor knowledge, conducting an accurate patient examination, the inability to correlate information obtained into a differential diagnosis, and requesting feedback. Dr. O'Malley discussed the concerns with respondent. The CCC was concerned as to whether respondent could improve enough to warrant keeping her in the program.

34. On September 23, 2013, Dr. Peterson reported that respondent's skills had worsened over the past six months. She was not able to remember information as well, or to put it together as she had done previously. Dr. Peterson acknowledged that respondent had worked hard to improve her medical knowledge, but found that she was having difficulty incorporating it into practice. Dr. Peterson provided respondent with strategies for improvement.

35. On October 9, 2013, the RAC informed respondent that despite having received specific feedback, letters of concern and remediation activities, she had not achieved the required milestones necessary to successfully complete the internship. Deficiencies spanned all of the Accreditation Council on Graduate Medical Education (ACGME) general competencies.³ In addition, she failed to perform the essential functions of a PGY-1. The RAC recommended that respondent be placed on six months' probation in the continued role of an intern. The letter notified respondent that performance would be reviewed every two months, with the possibility of termination from the program if insufficient improvement was noted. Respondent appealed the decision.

³ The ACGME is the national governing body that determines whether a residency program may be accredited. It has extensive rules and regulations for accredited programs. These include rules governing program curriculum and the evaluation of first year interns and second and third year residents to determine their competency, their ability to graduate and eligibility to become board-certified.

36. On November 25, 2013, the RAC met to hear respondent's appeal. Respondent presented a written plan of action. The RAC expressed concern that respondent's action plan focused on additional feedback and processes rather than outcomes. Respondent informed the committee that she was seeking professional help for personal and emotional issues that she felt were contributing to her poor performance. However, respondent failed to present evidence of achieving any of the required milestones or making meaningful progress in the two months since being notified of the RAC's recommendation. Respondent stated that she was reading 30 minutes each day, which the RAC advised her was insufficient for any resident, but especially in light of respondent's statements that she has difficulty with recall. The RAC advised respondent to read significantly more. The RAC wanted to see evidence of more extensive medical knowledge and an understanding of common and complex clinical disorders.

On December 3, 2013, the RAC denied respondent's appeal. The RAC outlined specific outcomes that respondent was expected to achieve in the areas of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, and professionalism. The RAC also outlined the essential functions of a PGY-1 and required that she demonstrate timely completion of program responsibilities. Respondent was required to work with her advisor on her action plan, to focus on outcomes, to create realistic expectations and to document her reading. The RAC upheld its recommendation and again warned respondent that should she fail to improve, she could be terminated from the program.

37. During December 2013, respondent worked at the VA and received weekly feedback on her performance.

38. On December 13, 2013, respondent underwent neuropsychological and cognitive testing. The testing identified mild cognitive decline and the evaluator diagnosed her with an anxiety disorder. Respondent was advised to follow up within 18 to 24 months.

39. On December 16, 2013, respondent received her intraining examination scores. The report is provided to help interns determine areas of strength and weakness. Respondent was ranked within her PGY level and provided with her percentile rank among the others in her level. Respondent scored as follows: cardiology and in endocrinology (9th percentile); gastroenterology (12th percentile); general internal medicine (33rd percentile); geriatrics (2nd percentile); hematology/oncology (1st percentile); infectious diseases (35th percentile); nephrology (8th percentile); neurology (13th percentile); pulmonology (5th percentile); rheumatology (7th percentile); and, high value care (7th percentile). Her percentile rank by PGY Level was 3rd.

40. In December 2013 respondent was assigned to the intensive care unit (ICU). The ICU attendings spent a lot of time with respondent. The ICU attendings concluded that at that time she was unable to perform as a resident. She improved on her history and physical examinations over time, was enthusiastic and hardworking. However, the attending physicians found her fund of knowledge was very weak and she was unable to answer

questions even with prompting. The group felt she was unable to work independently or to supervise a resident.

41. The CCC met on January 13, 2014, to discuss respondent's progress. Christopher Kurtz, M.D., reported that respondent's VA ward month was average except in the ability to manage both common and complex patient problems with minimal supervision. He gave her below average in her ability to identify "sick" patients and prioritize their problems, or supervise without supervision. Based on these deficiencies, Dr. Kurtz did not consider respondent competent to advance to PGY-2. Dr. Peterson reported that respondent was able to see her patient in clinic and plan a course of treatment; however, she only had one patient. Drs. Kurtz and Peterson were asked to submit specific examples to respondent to identify the issues upon which she needed to focus. The CCC decided respondent had made enough progress to continue as a PGY-1.

42. In February 2014, respondent was assigned to the VA night float rotation and received specific instructions to facilitate supervision. Meaningful feedback (weekly summary of targeted skills and review a log of patient encounters with the nocturnist for feedback and teaching) was provided. In March 2014, respondent was assigned to the VA ward rotation and continued to receive structured weekly feedback and was given suggested readings. Respondent's March 2014 evaluations were inconsistent.

43. Based on ongoing concerns and the conclusion of her respondent's six-month probation period, the RAC reconvened on April 10, 2014. In a letter dated April 28, 2014, the RAC stated it had concerns regarding respondent's ability to care for larger patient volumes and more complex patients as required of a senior resident continued. The RAC extended respondent's probationary period to give her the opportunity to demonstrate the ability to effectively manage complex patients in an efficient manner. She was encouraged to obtain written and verbal feedback on a weekly basis.

44. On April 23, 2014, Dr. Peterson met with respondent. Dr. Peterson advised respondent that she would be assigned to another ward rotation in May 2014, which was an opportunity to demonstrate that she had the skills to supervise others. Dr. Peterson warned respondent that if she was unable to demonstrate that ability, her contract might not be renewed.

45. On May 28, 2014, respondent's medical knowledge was noted to be deficient in the following ways:

- a) She was unable to point out a T wave on a normal electrocardiogram (EKG);
- b) She was unable to respond to handle critical labs;
- c) She could not manage a patient with an altered mental state;

- d) She was unable to triage patients in the order of acuity;
- e) She spent too much time reviewing charts;
- f) She was deficient in some basic medical concepts;
- g) She wanted to give acute heart failure exacerbation 500 cc bolus right after the patient received IV Lasix; and,
- h) She was unable to recognize or manage severe sepsis (she wanted to diurese the patient with dehydration and severe sepsis).

46. On June 5, 2014, Phillip Sirota, M.D., reported to Dr. O'Malley that respondent was not ready to be a supervising senior resident and he would feel uncomfortable having her admit patients without supervision. Dr. Sirota noted that respondent had not followed up on a suggestion that she learn how to obtain good review articles to better deliver patient care. Dr. Sirota also reported that respondent had difficulty prescribing the correct antibiotic for a specified condition. These issues were troubling for Dr. Sirota in light of the fact that respondent was at the end of her second year of post graduate training.

47. On June 11, 2014, Donna Holland, M.D., submitted an evaluation of respondent's performance in May 2014. The evaluation was based on her observations and those of Drs. Harper and Mallin. Respondent worked hard to improve and was never late. At times, however, respondent was able to identify a patient's clinical problems, but did not know what to do about it, or made an error in implementing a management plan, such as giving diuretics to a septic patient, giving intravenous fluids to a patient with heart failure, or calling gastrointestinal regarding a patient with a gastrointestinal bleed without doing any additional assessment about the urgency, suggesting aggressive measures for a non-urgent problem prior to considering alternatives with less risk.

Respondent's written communication had improved during the month; however, she was unable to consistently communicate the same information verbally. Her oral presentations were disorganized and unclear and did not demonstrate accurate and complete working knowledge of the patient. Respondent worked diligently to update her knowledge, but she had difficulty applying her knowledge to the patient in specific circumstances. Her medical knowledge was fragmented and incomplete, impairing her ability to make accurate assessments of her patients and implement appropriate treatment plans. She was unable to demonstrate an accurate or complete differential diagnosis for fever in a hospitalized patient. Respondent was inconsistently able to recognize urgent or emergent situations, and when she recognized an urgent need, she was unsure of how to manage the situation. Respondent struggled to get written documentation completed in a timely manner. She readily assumed responsibility for her patients, but her perceptions of her ability to do so appropriately was inflated and lacked insight. And, although respondent

asked for feedback from attendings, she was not always able to incorporate suggestions.

48. On June 12, 2014, the RAC met to review respondent's performance. The RAC found that during respondent's final three months on probation, the same type of concerns that had been identified at the beginning of her internship continued. The RAC concluded that respondent had failed to meet the ACGME milestones or the essential functions of a PGY-1, and failed to demonstrate her ability to perform as a PGY-2, with indirect supervision only.

49. On June 19, 2014, Drs. O'Malley and Peterson advised respondent that the RAC had determined that she had failed to complete her PGY1 year and had recommended that respondent's contract for PGY2 not be renewed.

50. Respondent appealed the decision. She submitted a statement in support of her appeal, but declined the invitation to appear. Respondent's arguments on appeal were: 1) the faculty's expectations were too high and they were hypercritical; 2) faculty should have done more to help her become a competent internist; and, 3) she was not given sufficient notification of non-renewal of her contract.

51. The RAC considered the appeal and determined that: 1) respondent was evaluated the same as her peers; 2) the program did everything possible to help her; and, 3) the ACGME requirements were followed.

On July 23, 2014, the RAC informed respondent that it upheld its recommendation to not renew her contract, and stated "After two years as a PGY-1, you are still not consistently demonstrating competence in the PGY-1 milestones."

The RAC ultimately gave respondent credit for completing the PGY-1 year with a rating of "marginal" in overall clinical competence.

52. In her statement in support of the recommendation of respondent's termination from the program, Dr. O'Malley wrote that termination of a resident is never easy, and it is not a decision that the RAC makes lightly. She noted that respondent's termination was particularly difficult as she had developed close relationships with the attending physicians, who wanted her to succeed. Dr. O'Malley reported that the program worked diligently to assist respondent in improving her knowledge and skills, including: additional rotations, a rotation at the Simulation Center, time outside of the residency to work on skills, one-on-one mentoring, letters of concern and probation. Despite these efforts, respondent lacked the necessary knowledge and skills to work as a PGY-2.

53. The recommendation not to renew respondent's contract was forwarded to the Graduate Medical Evaluation Committee (GMEC), but prior to the GMEC's consideration of the recommendation, on August 28, 2014, respondent submitted a letter of resignation.

U.S. Medical Licensing Examinations

54. Respondent failed the United States Medical Licensing Examination (USMLE) Step 1 on September 24, 2009, but passed Step 1 on March 22, 2010. Respondent passed Step 2 (Clinical Knowledge) on September 28, 2011, and Step 2 (Clinical Skills) on February 27, 2012. Respondent failed Step 3 on December 23, 2014; she passed Step 3 on September 1, 2015.

Respondent's Evidence

55. Respondent became interested in attending medical school while she was in high school. Her father was diagnosed with emphysema and as she cared for her father, respondent became interested in medicine. After teaching high school science for 10 years, respondent decided to apply to medical school.

56. Respondent was accepted to the University of Wisconsin School of Medicine and Public Health in 2007. Respondent's husband was unable to relocate due to his job. She made the difficult decision to leave her husband and three young children to attend medical school.

57. While in medical school, respondent experienced some extraordinary challenges. In addition to being away from her husband and children, respondent's father passed away in January 2010, her father-in-law passed away in April 2010, and she was diagnosed with breast cancer in October 2010. Respondent did not take a leave of absence during medical school; however, she took five years instead of four because she had to repeat some classes, retake the USMLE examination that she failed on September 24, 2009, and she had to repeat or delay some clinical rotations. As a result, respondent graduated in May 2012.

58. Respondent applied, and hoped to attend an internal medicine post-graduate program in California, but was matched with Banner Good Samaritan Medical Center in Phoenix, Arizona. Because she had been away from her children for five years while attending medical school, she and her husband decided that she would take the children and her mother with her to Arizona. Respondent's husband remained in California.

59. Respondent struggled during her internship year at Banner Good Samaritan Medical Center. She attributes part of the difficulty with trying to raise her three children in a new environment during her internship. In March 2013, aware that the CCC had serious concerns about her deficiencies, she volunteered to attend a month-long independent study in Champaign, Illinois, at her expense, to improve her medical knowledge.

60. After being advised that she did not meet the ACGME milestones and would not be promoted to PGY-2 in June 2013, respondent sent her children back to Fresno to live with her husband. Respondent was confident that if she were able to focus on her work, with the support of her supervisors, she would get back on track.

61. Respondent blames her superiors at Banner Good Samaritan Medical Center for failing to provide her with effective feedback throughout her training. When placed on six-month probation in October 2013, respondent did not understand why the CCC concluded that she had not made significant improvement. She sought help from a neurologist, obtained an MRI of her head, and began therapy with a psychologist. Respondent was under a great deal of stress. She sought treatment for performance anxiety. With treatment, she felt she was better able to focus.

62. In December 2013, respondent submitted to a complete neurological evaluation with Amy Knapp, M.D. Based on the results of the examination, Dr. Knapp concluded that respondent suffered from mild cognitive decline. Respondent does not agree with the results; she feels that the issue was the stress and pressure she was under at the time. Dr. Knapp recommended that she follow up on the findings in 18 to 24 months; respondent did not have time to do so.

63. In May 2014, respondent felt her skills had improved. She was surprised that one of the attendings remarked on short term memory problems; respondent advised the attending that she had learned to write things down so that she would not forget. Nevertheless, she received a poor evaluation from the attending physician. Respondent felt that the rating was unfair.

64. In June 2014, respondent was advised that her contract would not be renewed and that she would not receive credit for PGY-1 because she had not mastered the milestones. Respondent presented evidence seeking PGY-1 credit and asked to resign in lieu of termination. Respondent was given credit for PGY-1, but did not realize she would receive an overall evaluation of "marginal." Respondent resigned prior to the GMEC's decision, rendering the issue moot.

65. As a result of her experience at Banner Good Samaritan Medical Center, respondent decided that family medicine would be a better fit than internal medicine. In the fall of 2014, respondent applied for a family medicine residency program through the National Residency Matching Program. Respondent had interviewed with the SierraVista Family Medicine Residency Program in Fresno, California; however, the program lost funding and pulled out of the process. Respondent reports the program later contacted her outside of the match program to say that they had obtained funding and were interested in training her, but because her license had been denied, she was ineligible.

66. Respondent interviewed with the Sierra Vista program again on November 19, 2015. Lydia Herrera-Mata, M.D., the Program Director, wrote a letter for the Board's consideration dated May 10, 2016. Dr. Herrera-Mata was impressed with respondent's personal background and strong ties to the Fresno community. Respondent was not offered a position in the residency because she is not licensed to practice medicine in California. Dr. Herrera-Mata commends respondent for her perseverance in becoming a physician. Dr. Herrera-Mata has reviewed documents from respondent's residency training and letters of support and remains in support of respondent's application to the SierraVista Family

Medicine Residency Program.

67. Respondent will reapply this fall. She is not limiting her search to California. Respondent understands that only California and Connecticut limit the training exemption to 24 months; other states have a five-year exemption.

68. In November 2015, respondent began working with Mouatou Mouanoutoua, M.D., the Interventional Cardiology Fellowship Program Director at the University of California, San Francisco (UCSF), Fresno Medical Education Program. Respondent is working to improve her reading interpretations of EKG's.

69. Dr. Mouanoutoua testified at hearing on respondent's behalf. He has been with the UCSF Interventional Cardiology Fellowship Program since 2005. He has been the Director of the program for approximately five years. Prior to his work at the UCSF Fresno Medical Education Program, Dr. Mouanoutoua attended post graduate training: he attended three years in internal medicine, followed by three years in general cardiology, then one year in an interventional cardiology fellowship program, all at Sinai Samaritan Medical in Milwaukee, Wisconsin. He attended medical school at Ross University Medical School in the Caribbean.

Dr. Mouanoutoua first met respondent at an educational conference while he was in medical school. Approximately two years ago, respondent contacted him advice because she was struggling in her training program; he referred her to a colleague. In late 2015, respondent and her husband contacted him again. She wanted to study interpreting EKG readings. Respondent has been reviewing EKG's with Dr. Mouanoutoua on Wednesday mornings. Over the course of three or four months, he has noticed an improvement in respondent's ability to read EKG's; however, he does not test her formally.

70. Respondent also contacted Robert A. Forester, M.D., a family physician located in Modesto, California. Respondent spent a day shadowing Dr. Forester, who was very impressed by respondent's family and personal history. Dr. Forester commends respondent for her excellent interpersonal skills, maturity and grit. Respondent reports that she has shadowed Dr. Forester since May 2016.

71. Pao Moua, respondent's husband, submitted a declaration in support of respondent. Moua is a civil engineer with the Department of Transportation. He believes that respondent should be granted a license in California.

72. Respondent has completed approximately 26 hours of continuing medical education since leaving Banner Good Samaritan Medical Center. She also attended a 10-week course and four-day retreat entitled "Live Your Dream: Revolutionize Your Medical Practice" in the spring of 2016.

73. Dr. O'Malley, M.D., the Program Director of the Banner Good Samaritan Medical Center Internal Medicine Residency Program, wrote a letter dated September 30,

2014, in which she stated that although respondent struggled in her program, she was hopeful that respondent would ultimately achieve her dream. Dr. O'Malley considered respondent to be a dedicated physician who worked incredibly hard and sought feedback in order to improve. She reports that respondent was well-liked and received high marks for patient communication and professionalism. Dr. O'Malley reports that in light of her lack of contact and relationship with respondent, she is not equipped to assess her professional competence or fitness for licensure as a physician and surgeon in California.

74. Respondent presented a declaration from Dr. Peterson, the Chairperson of the CCC at Banner Good Samaritan Medical Center. Dr. Peterson also served as respondent's preceptor for the outpatient resident clinic. Dr. Peterson states that she is not in a position to assess respondent's professional competence or fitness for licensure as a physician and surgeon in California.

75. Respondent presented a declaration from Donna Long, M.D., a physician at Banner Good Samaritan Medical Center. Respondent was assigned to work with Dr. Long on four or five night shifts. Dr. Long relates that she has no concerns about respondent's competency or fitness for licensure.

76. My Yang, M.D., M.S., wrote a letter in support of respondent's licensure. Dr. Yang met respondent in medical school at the University of Wisconsin. Dr. Yang considers respondent to be an honest, ethical, team player, and describes her as an avid, curious and willing learner.

77. Juan R. Hernandez, a longtime friend of respondent's, wrote a letter in support of respondent's licensure. Hernandez considers respondent to be a person of impeccable honesty and integrity. He believes she would be an asset to the medical community in Fresno.

78. Ia Moua, respondent's sister-in-law, wrote a letter in support of respondent's licensure. She has known respondent for nearly 20 years and is aware of the challenges respondent has faced in medical school and in her internship. She very much supports respondent receiving a license to practice medicine in California.

79. Trer Vang wrote a letter in support of respondent's licensure. Vang met respondent in 1998 at California State University at Fresno where she obtained his teaching credential. Vang is very impressed with respondent's perseverance in following her dream to be a doctor despite many challenges.

80. Respondent has had two sessions with a psychologist and will follow up with neuropsychological testing on September 13 and 22, 2016. She anticipates receiving the results of the testing on October 3, 2016.

Expert Testimony

JAMES NUOVO, M.D.

81. Complainant called James Nuovo, M.D., as an expert witness. Dr. Nuovo is a licensed California physician with a specialization in Family and Community Medicine. He is board-certified by the American Board of Family Medicine and has been affiliated with the University of California at Davis School of Medicine (UC Davis) since 1992. Dr. Nuovo is the Associate Dean for Graduate Medical Education and the vice-chair of the Department of Family and Community Medicine at UC Davis. He has authority and responsibility over all residency training programs. UC Davis has over 60 residency and fellowship programs and over 800 residents and fellows. Dr. Nuovo must ensure that each of these training programs meets the ACGME accreditation requirements, including that residents are afforded due process when they are not meeting their performance standards. In addition, Dr. Nuovo ensures that all residents have the training opportunities necessary for them to meet their specialty requirements. Dr. Nuovo has also served as a medical consultant to the Board in various capacities.

82. Dr. Nuovo has had numerous opportunities to evaluate residents who are struggling. Approximately five percent of residents at any time in a year are having performance issues to the level that they receive a letter of concern. Each year one or two residents are dismissed or terminated from the program. Sometimes the issue involves substance abuse; other residents lack medical knowledge or patient care skills and are not able to be remediated.

83. At complainant's request, Dr. Nuovo reviewed respondent's application and documents received from Banner Good Samaritan Medical Center. After reviewing the documentation, Dr. Nuovo was not surprised that respondent's contract was not renewed. The evidence in the record was that respondent had been given two years to complete an internal medicine internship, which normally takes one year, and she had repeated specific performance deficiencies despite efforts to remediate and correct those deficiencies. Even at the end of two years, respondent was unable to remediate the performance problems. Respondent demonstrated global performance deficiencies that, in Dr. Nuovo's opinion, were remarkable, unusual and extremely concerning.

Dr. Nuovo does not believe that a change from internal medicine to family medicine would make any difference. Dr. Nuovo is a family physician, has trained residents in family medicine for 32 years and is quite familiar with the kinds of cases family physicians see regularly. Some of the deficiencies that were observed are common issues in family practice, such as urinary tract infections or treatment of diabetes. A family physician needs these skills to practice safely.

84. Dr. Nuovo opined that respondent should not be given a license to practice medicine in California. After two years of internship, respondent was unable to improve sufficiently to be promoted. Respondent failed to remediate despite timely feedback about

specific performance deficiencies, and had the opportunity to engage in a corrective plan to address each concern; and yet, even at the end of the second year, she was unable to demonstrate the ability to practice safely and competently. In addition, respondent's intraining examination scores were very low, and the mistakes that she made in the last few months of her internship were serious errors and could have harmed her patients.

In Dr. Nuovo's opinion, the problems were significant and serious and involved fundamental skill deficiencies. Because of what he perceived as the global deficiencies in the core competencies and respondent's failure to remediate, Dr. Nuovo concluded that respondent is not competent and is unsafe to practice medicine in California.

VANESSA MCPHERSON, M.D.

85. Respondent presented expert testimony from Vanessa McPherson, M.D. Dr. McPherson earned her medical degree from the University of North Carolina in 1994. She completed a residency in family medicine at the Richland Memorial Hospital/University of South Carolina in 1997. Dr. McPherson has been board certified in family medicine since 1997. She attended a faculty development fellowship at the University of North Carolina Department of Family Medicine in 2002, and attended the National Institute for Program Director Development from 2004 to 2005. Dr. McPherson has been engaged in private practice at the Southpoint Family Practice in Belmont, North Carolina since 2000. She has been a full professor at the Department of Family Medicine, Carolinas Medical Center since 2013.

From August 2003 to April 2013, Dr. McPherson was the Residency Director of the Family Medicine Residency, Department of Family Medicine, Carolinas Medical Center in Charlotte, North Carolina. From April 2013 until June 2016, Dr. McPherson served as the Residency Director, Family Medicine Residency Program at Carolinas Medical Center-Union, in Monroe, North Carolina. Respondent left the residency program and is in private practice.

As the Residency Director, Dr. McPherson had responsibility for the oversight of the entire residency program, including recruitment, selection of residents, overseeing training, competency, development and attaining their milestones. Dr. McPherson was also involved in disciplinary matters and remediation plans for the residents. There were 36 residents in the Charlotte program each year. Dr. McPherson has not overseen residency training in California, but notes that all medical training requires certain cognitive skills, medical knowledge, the ability to self-regulate, self-monitor or professionalism. The six core competencies that are laid out by the ACGME are common to all special training.

86. Dr. McPherson was asked to render an opinion on respondent's competency. Before reviewing the records from Banner Good Samaritan Medical Center, she chose to do her own assessment of respondent's clinical skills by way of a two-hour objective structured clinical examination (OSCE), which is a common method used to test residents' clinical skills. Dr. McPherson selected two specific stations from the OSCE, one inpatient case and

one from an outpatient setting. Both were fairly common types of patient presentations encountered by a family medicine intern.

The inpatient case involved a patient with congestive heart failure. He had an atrial fibrillation, a common cardiac presentation. The patient was arriving at the emergency room with shortness of breath and Dr. McPherson was looking for a global assessment. Dr. Xiong did very well and correctly read the patient's EKG. There were no significant deficiencies; however, respondent recommended Albuterol, a medication used for asthma or chronic obstructive pulmonary disease, which was not necessary for the patient, but not harmful either.

The outpatient case did not go as well. The patient was coming into the office complaining of pain under her feet. She was having to get up at night to urinate frequently. She did not have a previous history of diabetes or exhibiting symptoms of diabetes. Respondent missed some elements on the history and did not perform a neurological examination as part of the physical examination. As a result, the assessment and plan was incomplete. Respondent missed the diagnosis of diabetes and neuropathy. Dr. McPherson felt that her failing might reflect a relative lack of outpatient training.

Dr. Nuovo considered respondent's failure to correctly diagnose the patient in the outpatient scenario, who had symptoms typically seen in family medicine, to reaffirm his opinion that respondent should not be licensed in California.

87. After completing the OSCE's, Dr. McPherson read the records from Banner Good Samaritan Medical Center, respondent's application, the statement of issues, and letters from Drs. O'Malley, Peterson, Herrera-Mata and Long. Dr. McPherson contacted Drs. O'Malley, Peterson and Herrera-Mata. Drs. Peterson and Herrera-Mata did not return her calls and Dr. O'Malley referred Dr. McPherson to her previous letter.

Dr. McPherson spoke with respondent on the telephone to determine whether respondent had gained any insight into the concerns raised by Banner Good Samaritan Medical Center. Dr. McPherson recommended that respondent immerse herself in seeking medical knowledge, seeking out continuing medical education, and getting some broad clinical exposure such as in family medicine to brush up on her clinical skills.

88. If Dr. McPherson had been overseeing respondent's residency, she would have followed up on the neuropsychiatric examination that revealed that respondent was experiencing stress, anxiety and mild cognitive decline. The evaluators diagnosed respondent with an anxiety disorder and recommended counseling. The evaluators found mild cognitive impairment that was significant enough for them to list it in their recommendations, including with a number of precautions, such as with driving. The report also identified issues with judgment, which clinical medicine requires. Dr. McPherson recommends that another neuropsychiatric evaluation be completed to determine whether the issues have resolved or persisted.

89. Based on her review of all of the information, Dr. McPherson did not consider respondent unable to remediate. If an updated neuropsychiatric evaluation does not reveal an impairing condition, Dr. McPherson would support respondent receiving a probationary license that includes any recommended therapy; she would restrict respondent to a residency training program in which she would be supervised. Dr. McPherson believes that respondent would perform better in a smaller residency program, one with one-on-one training. After respondent reaches appropriate milestones, she could practice unsupervised.

90. Respondent does not object to a probationary license, but feels she should be permitted to moonlight during her residency as a result of having completed her internship.

Expert Testimony Evaluation

91. Dr. Nuovo has more experience in evaluating residents and has been licensed in California for many years. He has significant experience with California's licensure requirements and has evaluated issues for the Board over the past 15 or more years. In addition, Dr. Nuovo's opinions reflected the findings of the Banner Good Samaritan Medical Center residency program.

By contrast, Dr. McPherson has never been licensed or practiced in California. Dr. McPherson's opinion that respondent should receive a license in California was undermined by her concerns that respondent did not follow up on the recommendations in the 2013 neuropsychiatric evaluation and by the lack of an updated evaluation, which she felt was an important prerequisite to licensure. In addition, her conclusions are at odds with respondent's failure to perform well on one of the two OSCE's she prepared.

LEGAL CONCLUSIONS

1. Respondent has the burden of proving by a preponderance of the evidence that she should be granted a license. (*Martin v. Alcoholic Beverage Control Appeals Bd.* (1959) 52 Cal.2d 259, 264-265; Evid. Code, §§ 115, 500.)

Cause for Denial

2. Pursuant to Business and Professions Code section 2096, an applicant graduating from a medical school located in the United States must show by evidence satisfactory to the Board that he or she has satisfactorily completed at least one year of postgraduate training.

Cause for denial does not exist pursuant to Business and Professions Code section 2096 because respondent established that she satisfactorily completed one year of postgraduate training.

3. Business and Professions Code section 480, subdivision (a), authorizes the Board to deny a license to an applicant who has done an act that if done by a licensee would be grounds for suspension or revocation of the license.

Pursuant to Business and Professions Code section 2221, the Board may deny a physician's and surgeon's certificate to an applicant guilty of unprofessional conduct. Unprofessional conduct is defined in Business and Professions Code section 2234 to include gross negligence, repeated acts of negligence and incompetence.

Discussion

4. Business and Professions Code section 2229 mandates protection of the public shall be the highest priority for the Board.

5. As explained by Dr. Nuovo, the problems that occurred at Banner Good Samaritan Medical Center were significant and serious and involved fundamental skill deficiencies. (Factual Findings 83 and 84.) Moreover, respondent has demonstrated a lack of insight into her deficiencies, and has at times blamed others for her failures. (Factual Findings 16, 17, 36, 47, 50, 61, 62, 63 and 90.) During her internship, numerous attending physicians and senior residents concluded that respondent was not competent and/or she lacked a foundation of medical knowledge. (Factual Findings 12, 16, 17, 26, 27, 32 through 36, 40, 41, 45 and 52.) And, at times she failed to follow recommendations aimed at increasing her medical knowledge. (Factual Findings 17 and 41.)

Respondent was given numerous opportunities to remediate and was provided with extensive coaching and support throughout her residency; and yet, she failed to improve. (Factual Findings 9 through 52.) After two years of internship, she was initially denied credit, and ultimately given credit with a marginal rating in overall competency. (Factual Finding 51.) Her examination scores were consistent with her performance. (Factual Findings 7, 14, 39 and 54.)

Respondent's global deficiencies in the core competencies and her failure to remediate over a two-year period demonstrate that respondent is not competent and is unsafe to practice medicine in California. (Factual Findings 83 and 84.) As such, respondent's conduct would be grounds for suspension or revocation of a physician's and surgeon's certificate. Cause for denial of respondent's application has been established.

6. Respondent's evidence at hearing did not demonstrate that she is safe to practice. Her expert's support was conditioned upon an updated neurological examination and close supervision in a residency program. Significantly, her performance on the two OSCE's administered by Dr. McPherson raised fresh concerns about her competency to practice medicine. (Factual Findings 86 through 89.) Respondent did not meet her burden of establishing that her application should be granted even on a probationary basis. Protection of the public requires denial of respondent's application for licensure in California.

ORDER

The application of Kaying Xiong for a physician's and surgeon's certificate is denied.

DATED: November 3, 2016

DocuSigned by:

Jill Schlichtmann

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JILL SCHLICHTMANN
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Statement of Issues
Against:

KAYING XIONG, M.D.

**1153 E. Paul Avenue
Fresno, CA 93710**

Applicant.

Case No. 800-2015-015789

STATEMENT OF ISSUES

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Statement of Issues solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about December 9, 2014, the Medical Board of California, Department of Consumer Affairs received an application for a Physician's and Surgeon's certificate from Kaying Xiong, M.D. ("Applicant"). On or about December 2, 2014, Kaying Xiong, M.D. certified under penalty of perjury to the truthfulness of all statements, answers, and representations in the application. On or about July 15, 2015, the Board denied Applicant's application. In correspondence dated July 24, 2015, Applicant requested an administrative hearing.

JURISDICTION

3. This Statement of Issues is brought before the Medical Board of California ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2221 of the Code states:

"(a) The board may deny a physician's and surgeon's license to any applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license."

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

". . . (d) Incompetence."

6. Section 2096 of the Code states:

"(a) In addition to other requirements of this chapter, before a physician's and surgeon's license may be issued, each applicant, including an applicant applying pursuant to Article 5 (commencing with Section 2100), except as provided in subdivision (b), shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least one year of postgraduate training."

7. Section 480 of the Code states:

"(a) A board may deny a license regulated by this code on the grounds that the applicant has one of the following:

". . . (3) (A) Done any act that if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license."

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1 f. In or about March 2013, due to performance concerns as well as Applicant's
2 request to perform additional remediation activities, Applicant was removed from her scheduled
3 rotations as a VA night float doctor.

4 g. In or about April 2013, again due to concerns about her performance, Applicant
5 was pulled off her VA duties and was required to complete a remediation rotation at Simulation
6 Center.

7 h. On or about June 28, 2013, Applicant was issued a letter of concern by CCC.
8 The letter indicated that Applicant had not completed the requirements of the internship, despite
9 three (3) months of remediation. Applicant was then given three (3) additional months to work as
10 an intern.

11 i. In or about August 2013, while doing an ambulatory rotation, Applicant's
12 schedule was modified to lower her patient volume.

13 j. On or about August 29, 2013, Applicant was issued a letter of concern by CCC.
14 The letter indicated Applicant's performance remained deficient, and Applicant's schedule was
15 modified to lower the patient volume. The letter also indicated that Applicant was unaware of her
16 deficiencies and that Applicant was not demonstrating initiative to improve.

17 k. On or about October 9, 2013, the Internal Medicine Resident Advisory
18 Committee ("RAC") informed Applicant that due to her failure to achieve the required milestones
19 necessary to succeed in the internship Applicant would be placed on six (6) months probation.
20 Under the probationary terms, Applicant's performance was to be reviewed every two (2)
21 months, with the possibility of termination from the program if insufficient improvement was
22 noted. Applicant appealed the decision.

23 l. On November 27, 2013, RAC met to hear Applicant's appeal. RAC upheld its
24 recommendation and again warned Applicant that should she fail to improve, Applicant could be
25 terminated from the program.

26 m. On or about April 28, 2014, RAC noted that Applicant had completed six (6)
27 months on probation and that concerns continued regarding Applicant's ability to care for larger
28

1 patient volumes and more complex patients as required in the role of a senior resident. Therefore,
2 Applicant's probation was extended.

3 n. On or about May 28, 2014, the following was noted regarding Applicant's
4 medical knowledge:

- 5 i. Unable to point out a T wave on a normal ECG;
- 6 ii. Unable to respond to handle critical labs;
- 7 iii. Could not manage a patient with altered mental status;
- 8 iv. Unable to triage patients in order of acuity;
- 9 v. Spend too much time chart reviewing;
- 10 vi. Deficient in some basic medical concepts;
- 11 vii. Wanted to give acute heart failure exacerbation 500 cc bolus right after a
12 patient received IV Lasix;
- 13 viii. Unable to recognize or manage severe sepsis, i.e., wanted to diurese
14 patient with dehydration and severe sepsis.

15 o. In correspondence dated June 12, 2014, RAC stated that Applicant failed to
16 successfully complete her PGY-1 year and RAC recommended that Applicant's contract for
17 PGY2 not be renewed.

18 p. On or about June 19, 2014, RAC recommended that Applicant's contract not
19 be renewed.

20 q. In correspondence dated July 23, 2014, RAC informed Applicant that "After
21 two years as a PGY-1, you are still not consistently demonstrating competence in the PGY-1
22 milestones."

23 r. In that same correspondence dated July 23, 2014, RAC noted that Applicant
24 had "completed 24 months at a PGY1 level and that you completed the PGY1 year in Internal
25 Medicine with a rating of 'marginal' in your overall clinical competence."

26 s. On or about August 28, 2014, Applicant submitted a letter of resignation to the
27 Graduate Medical Education Committee.

1 t. In addition to the postgraduate studies listed above, on the dates listed below
2 Applicant underwent the following United States Medical Licensing Examinations (“USMLE”):

- 3 i. On or about September 24, 2009 – USMLE Step 1 – fail;
4 ii. On or about March 22, 2010 – USMLE Step 1 – pass;
5 iii. On or about September 28, 2011 – USMLE Step 2 CK – pass;
6 iv. On or about February 27, 2012 – USMLE Step 2 CS – pass;
7 v. On or about December 23, 2014 – USMLE Step 3 – fail;
8 vi. On or about September 1, 2015 – USMLE Step 3 – pass

9 10. The information pertaining to Applicant that was received from the Banner Good
10 Samaritan Medical Center in Phoenix, Arizona, was provided to Jim Nuovo, M.D. to review.
11 After review of that information, Dr. Nuovo opined that the Applicant’s medical performance
12 deficiencies were global in nature and rendered her unsafe to practice medicine and that no
13 safeguards would make her safe to practice on probationary terms.

14 CAUSE FOR DENIAL OF APPLICATION

15 (Unprofessional Conduct/Incompetence)

16 11. Applicant's application is subject to denial under sections 2096 [failure to
17 satisfactorily complete postgraduate training], 480(a), 2221, 2234 [unprofessional conduct], and
18 2234(d) [incompetence], in that Applicant’s clinical deficiencies would likely place patients at
19 risk for harm, and that Applicant’s conduct which, if done by a licentiate, would be grounds for
20 suspension or revocation of license, i.e., unprofessional conduct and/or incompetence.

21 PRAYER

22 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
23 and that following the hearing, the Medical Board of California issue a decision:

24 1. Denying the application of Kaying Xiong, M.D. for a Physician's and Surgeon's
25 certificate;

26 2. If issued a probationary license, ordering Applicant to pay the Medical Board of
27 California the costs of probation monitoring upon order of the Board;

1 3. If placed on probation, revoking, suspending or denying approval of the Applicant's
2 authority to supervise physician assistants; and,

3 4. Taking such other and further action as deemed necessary and proper.

4
5 DATED: November 24, 2015


KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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